STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BAYSIDE OF POQUOSON	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/4/15 through 3/6/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 52 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #12, and #14) and 1 closed record review (Residents #13)	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	**Disclaimer:** **Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in this statement of deficiencies. This Plan of Correction is prepared and /or executed solely because it is required by the provision of Federal and State Laws.** RECEIVED MAR 30 2015 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Karen D. Pond | Executive Director | 3-23-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, facility documentation and review of the facilities policy, the facility staff failed to report to the State Agency and investigate an unusual occurrence for 1 of 14 Residents (Resident #7) in the survey sample. The facility staff failed to report to the State Agency (SA) and thoroughly investigate after Resident #7 was found on the floor with a left hip fracture when the occurrence was unwitnessed and could not be explained by the resident. The findings included: Resident #7 was originally admitted to the facility 8/9/10 and readmitted 11/21/14 after an acute	F 225	**F- 225** 1. 100 % audit of all un-witnessed falls with injury in the last 30 days . 2. 100% audit of all of all falls with injury. 3. ED/ Designee to track all un-witnessed fall and /or falls with injury will be investigated and report to the SA when needed. Staff in serviced on policy on reporting. 4. ED or designee will track all falls with injuries monthly and results of tracking will be discussed at QAPI for at least 3 months. 5. Date of completion April 17, 2015.	

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F 225	Continued From page 2 admission to a local hospital. The current diagnoses are dementia, with delusional features, vitamin D deficiency, depression, osteoporosis, coronary artery disease, hypertension, hearing loss and acid indigestion. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/16/15 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired decision making abilities. In section "G" (Physical functioning) Resident #7 was coded as requiring limited assistance of 1 person with locomotion off the unit, extensive assistance of 1 person with bed mobility, locomotion on the unit and extensive assistance of 2 person with transfers. Resident #7 was also coded at "G0300" as only able to stabilize with staff assistance during transfers between the bed and chair/wheelchair. A lap buddy restraint was used daily when the resident was out of bed in the wheelchair. A lap buddy is a cushioned devise that fits in a wheelchair and assists in reminding person not to get up without assistance and also may be used as a positioning device. Resident #7 scored 12 on the 10/17 /14 fall risk assessment. This deemed Resident #7 a "resident at risk for fall."	F 225		

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F 225	Continued From page 3 Resident #7 was observed on 3/5/15 at approximately 11:40 a.m. sitting in the dining room in a wheelchair with a lap buddy in place. The surveyor introduced self to Resident #7 but the resident did not respond. The surveyor told Resident #7 about the impending weather and waited for a response but there was none. The care plan dated 3/20/13 identified Resident #7 was at risk for falls related to lack of safety awareness and impaired mobility. The care plan had goals of will have no fall related injuries through the next review 6/2/15 and reduce number of falls through next review 6/2/15. The care plan interventions included; activity programming - involve her in activities of choice. anti-rollbacks to wheelchair. apply gripper socks at night. attempt to redirect in periods of wandering. Avoid putting resident to bed too early due to impulsiveness and restlessness. frequent visualization by staff for safety. Toilet before bed... Mats to floor bedside bed when in bed. (added 1/12/15). The nurse's note dated 11/16/14 written at 21:45 p.m. indicated Resident #7 was found on the floor on the left side grabbing the left extremity, crying out in pain. Unable to move extremity during initial assessment. On 3/6/14 at approximately 1:30 p.m. an interview was conducted with the Executive Director (ED). The ED stated based on the information received during an internal investigation, which included	F 225		

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F 225	Continued From page 4 statements from the Licensed Practical Nurse (LPN) and Certified Nurses' Assistant (CNA) who were on duty when Resident #7 was found on the floor, the incident was found not reportable. The assumption was Resident #7 had fallen and the ED stated "in this environment falls and fractures are not considered unusual occurrences." The ED presented a document which stated the Director of Nursing Services (DNS) and Area Vice President confirmed the occurrence was not reportable based on the staff interviews. The surveyor was unable to speak with the LPN but the Verification of Investigation report completed by the LPN on 11/16/14 stated Resident #7 "was found lying on the left side crying out in pain to left lower extremity. Resident noted with rotation to left leg. No redness at this time. Resident crying and guarding left extremity and unable to explain how she ended up on the floor. Resident to have bed/chair alarm on at all times. Continue with toileting schedule, lap buddy to be in place while up in wheelchair. Resident injury as result of fall and attempt to ambulate without assistance. CNA #50 found resident lying on floor, grabbing left extremity crying my leg, my leg is hurting me! CNA #50 reported to 3 p.m. - 11 p.m. charge nurse immediately." An interview was conducted with CNA #50 on 3/6/14 at approximately 3:45 p.m. CNA #50 stated she was not assigned to care for Resident #7 but she was making rounds on the hall checking for alarms, residents requiring assistance, and ensuring all residents were safe and in bed when she observed Resident #7 on the floor in front of the closet in her room. CNA	F 225		

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F 225	Continued From page 5 #50 stated Resident #7 was dressed in a hospital gown and wearing nonskid shoes. CNA #50 stated Resident #7 was not calling out and she does not recall hearing an alarm sounding but the alarm box was attached to the bed but she was unable to see if the alarm was on. CNA #50 also stated Resident #7 was not holding onto or guarding any body part and she was not crying or making any comments. CNA #50 further stated she has never heard the resident make a express a complete thought such as "my leg, my leg is hurting me." The facility's policy titled Reporting Alleged Abuse Violations dated 1/15/15 indicates on page 3 under Reporting ... The ED notifies the appropriate state agency in accordance with state law and the regional vice president. The facility's policy titled Reporting Alleged Abuse Violations dated 1/15/15 indicates on page 4 the ED or DNS conducts all investigations. In the event an alleged violation occurs when neither of these people are in the center, the charge nurse is responsible for initiating the investigation procedure. The investigation includes interviews of employees, visitors or resident who may have knowledge of the alleged incident. Only factual information is documented, not assumptions or speculation. The above findings were shared with the Executive Director and Director of Nursing Services on 3/6/15 at approximately 5:45 p.m. No additional information was provided prior to the exit.	F 225		

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F 279 F 279 SS=D	Continued From page 6 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, facility staff failed to complete a comprehensive care plan by the 21st day for 1 out of 14 residents, Resident #8. The findings included: Resident #8 was originally admitted to the facility on 2/11/15, with diagnoses which included but not limited to dementia, hypertension, stroke, acidosis, altered mental status.	F 279 F 279	**F -279** 1. Resident # 8 care plan was updated on 3-5-2014. 2. All new admissions care plans were audited on 3-9-2015 to ensure the care plan was completed by day 21. 3. Staff will be educated on policy on care plans and RNAC to track all new admissions to ensure the care plan is completed per policy. ED / Designee will audit RNAC tracking log weekly to ensure compliance. 4. RNAC will track all new admissions to ensure care plan is developed per policy and audits will be discussed at QAPI for minimum of 3 months. 5. Date of completion April 17 , 2015.	

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F 279	Continued From page 7 Review of the Resident #8's clinical record revealed the most current MDS (Minimum Data Set- an assessment protocol), an Admission, with an ARD (assessment reference date) of 2/18/15. Resident #8's BIMS score (Brief Interview for Mental Status, an interview to assess mental status) was assessed as a 7 out of a possible 15 indicating severe cognitive impairment. On 3/6/15 at approximately 11:00 a.m., Resident #8's care plan was reviewed. The care plan read as follows: "Focus: Potential for drug related complications associated with the use of psychotropic medications related to antipsychotic medication: Date initiated 3/5/15" "Goal: Will be free of psychotropic drug related complications through next review. Date initiated: 3/5/15, Revision on: 3/5/15" "Interventions: Assess for pain each shift and prn (as needed), monitor for side effects and report to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS (extrapyramidal side effects), weight gain, edema, postural hypotension (low blood pressure when standing up from sitting or lying position), sweating, loss of appetite, urinary retention. Monthly pharmacy review of medication. Provide medications as ordered by the physician and evaluate for effectiveness. Psychotropic medication risk/benefit and reduction plan as recommended by physician and pharmacist. Date initiated 3/5/15, Revision on 3/5/15" Resident #8's 21st day at the facility was 3/4/15.	F 279		

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F 279	Continued From page 8 On 3/6/15 at approximately 2:00 p.m., the MDS Coordinator was made aware of the findings. The MDS Coordinator furnished the Care Plan invitation to the family and the Care Plan Conference sign in sheet. The surveyor asked the MDS Coordinator, "Should Haldol been included in the care plan meeting that was held on 2/25/15?" The MDS Coordinator stated, "Yes, nursing should have added it then." The Surveyor asked the MDS Coordinator, "Was nursing at this care plan meeting?" The MDS Coordinator stated, "No, nursing should have been there." On 3/6/15 at approximately 5:15 p.m., the Administrative team was made aware of the findings. The surveyor informed the team that the care plan was to be developed on the 21st day of admission. The administrative team provided the policy titled, "RAI (Resident Assessment Instrument) Process, with a revision date of 11/13/13. Policy Statement: Living Centers adhere to all CMS (Centers for Medicare and Medicaid) regulations which are considered the definitive source in completion of the RAI process. This includes coding the MDS, completion of Care Assessments, and the development of the comprehensive care plan. All Living Centers will utilize the CMS RAI (Resident Assessment Instrument) Manual for completion and compliance of the RAI manual.	F 279		

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F 280 F 280 SS=D	Continued From page 9 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and review of the facility's policy the facility staff failed to revise the care plan as the resident's status changed and new interventions were instituted for 1 of 14 residents (Resident #7), in the survey sample. The facility staff failed to revise Resident #7 care plan to include interventions to prevent falls.	F 280 F 280	**F- 280** 1. Resident #7 care plan was revised on 3-6-2015 . 2. 100% audit of all resident with falls in the last 30 days to ensure care plan is revised 3. Staff educated on policy for revision of care plan 4. RNAC will track all falls weekly to ensure care plans are updated and revised. Audits to be discussed at QAPI for a minimum of 3 months. 5. Date of completion April 17, 2015.	

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F 280	Continued From page 10 Resident #7 was originally admitted to the facility 8/9/10 and readmitted 11/21/14 after an acute admission to a local hospital. The current diagnoses are dementia, with delusional features, vitamin D deficiency, depression, osteoporosis, coronary artery disease, hypertension (high blood pressure), hearing loss and acid indigestion. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/16/15 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired decision making abilities. In section "G" (Physical functioning) Resident #7 was coded as requiring limited assistance of 1 person with locomotion off the unit, extensive assistance of 1 person with bed mobility, locomotion on the unit and extensive assistance of 2 person with transfers. Resident #7 was also coded at "G0300" as only able to stabilize with staff assistance during transfers between the bed and chair/wheelchair. A lap buddy restraint was used daily when the resident was out of bed in the wheelchair. A lap buddy is a cushioned devise that fits in a wheelchair and assists in reminding person not to get up without assistance and also may be used as a positioning device. Resident #7 scored 16 on the 11/21 /14 fall risk assessment. This deemed Resident #7 a "resident at risk for fall."	F 280		

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F 280	Continued From page 11 The care plan dated 3/20/13 identified Resident #7 was at risk for falls related to lack of safety awareness and impaired mobility. The care plan had goals of 'will have no fall related injuries through the next review 6/2/15' and 'Reduce number of falls through next review 6/2/15.' The care plan interventions included; activity programming - involve her in activities of choice. anti-rollbacks to wheelchair. apply gripper socks at night. attempt to redirect in periods of wandering. Avoid putting resident to bed too early due to impulsiveness and restlessness. frequent visualization by staff for safety. Toilet before bed... Mats to floor bedside bed when in bed. (added 1/12/15). An interview with the Rehabilitation Director on 3/6/15 at approximately 4:00 p.m. revealed multiple interventions instituted had not been added to Resident #7 care plan. They included a trial modification of the lap buddy, staff education on positioning in the wheelchair, issuance of a high back wheelchair for increased cervical and trunk support, and ongoing monitoring for episodes of fatigue. An interview was conducted with the MDS coordinator on 3/6/15 at approximately 5:15 p.m. The MDS coordinator was asked by the surveyor why were the Rehabilitation department interventions not added to Resident #7 care plan after Rehabilitation screens were requested by the Interdisciplinary Team (IDT) after falls. The Rehabilitation interventions were documented in the medical record but not on the current care plan. The MDS coordinator stated it is the	F 280		

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F 280	Continued From page 12 responsibility of the nurses on the unit to update the care plan. The facility's policy titled Resident Assessment Instrument Process dated 11/28/13 stated All Living Centers will utilize the CMS (Centers for Medicare and and Medicaid Services) RAI (Resident Assessment Instrument) Manual for completion and compliance of the RAI process. The RAI manual states the care plan must be reviewed and revised periodically and the services provided or arranged must be consistent with each residents written plan of care... The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. (RAI manual, MDS 3.0 chapter 4 page 4-8) The above findings were shared with the Executive Director and Director of Nursing Services on 3/6/15 at approximately 5:45 p.m. No additional information was provided prior to the exit.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview, facility documentation review and clinical record review, the facility staff failed to ensure a validated physician's order was followed for one (1) resident (Resident #2) of a fourteen (14) resident survey sample. Resident #2 had a validated physician order dated 11/28/14, as follows: "Restorative nursing effective 09/17/14 for at least 15 minutes 6x/wk (six times a week) and to include ambulation with patient CGA (close contact guard assistance) to/from dining room for meals." The facility staff was not observed to follow the physician's order. The findings included: Resident #2 was admitted to the facility on 05/27/14. Diagnoses included but were not limited to ORIF (open reduction of internal fixation) for fractured left hip, hypertension, urinary retention, chronic UTIs (urinary tract infections), DJD (degenerative joint disease) and Diastolic Heart Failure. Review of the resident's clinical medical record revealed a Quarterly MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 02/11/2015. The resident's BIMS (brief interview for mental status) score was coded as an 11 which indicates the resident's cognitive status is moderately impaired as evidenced by poor decisions and cues and supervision are required to meet her ADLs (activities of daily living) and safety. Further review noted the resident required extensive assistance by one staff member for bed mobility,	F 309	**F- 309** 1. Resident # 7 had restorative program started on 3-6-2015. 2. 100% audit of residents with restorative order was conducted on 3-9-2015. 3. RNAC/ Designee will audit restorative programs weekly for compliance. 4. RNAC or designee will track restorative programs and results of tracking will be discussed at QAPI for at least 3 months. 5. Date of completion April 17, 2015.	

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F 309	Continued From page 14	F 309		

dressing, eating, toilet use and personal hygiene. Regarding walking in room and walking in corridors the resident was coded as an 8 which indicated the activity did not occur. The resident was coded as requiring supervision for locomotion on and off the unit with the use of a wheelchair. The resident's functional limitation in range of motion was coded without impairments to the upper extremities but impairment was coded for one side of the body for lower extremity (hip, knee, ankle, foot). The resident was also coded as having an indwelling catheter to control the bladder and was always continent of bowel.

Review of the resident's current POS (physician order sheet) noted the following: "11/28/2014-Restorative nursing effective 09/17/2014, for at least 15 minutes to include ambulation with patient CGA (contact guard assistance) to and from dinning room for meals."

Throughout the survey of 03/10/15 through 03/12/15, there were not any observations by any members of the survey team of the resident being ambulated to and from the dining room for meals. Observations were made of the resident self-propelling herself throughout the facility in a wheelchair.

An interview was conducted on 03/06/15 at approximately 12:55 p.m., with Resident #2. When asked if she walked with anyone assisting she stated: "Once or twice a week if they aren't too busy." When asked if she would like to walk more she stated: "Yes."

An interview was conducted on 03/06/2015 at approximately 1:47 p.m., with the DON (director of nursing). When asked about the Restorative

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F 309	Continued From page 15 Program she stated: "That is started by the Rehab Department which gives the recommendation to nursing and then nursing passes the recommendation to the doctor for approval." The DON was then asked what staff members were trained to be able to perform the Restorative Program she stated: "All of the CNAs (certified nursing aides) here are trained by the Rehab Department when hired and as needed." An interview was conducted on 03/06/2015 at approximately 2:12 p.m., with RN (registered nurse) #2. RN #2 stated that she was the nurse that the Rehabilitation Department contacts in regards to any Restorative Program needs and recommendations. When asked about the Rehab order to start the Restorative Program on 09/17/2014 and was not addressed by the physician until 11/282014, she stated: "It must have gotten missed." Review of the resident's ADL (activities of daily living) Flow Sheet Log dated 12/07/14-03/06/2015 noted an 8 (denotes the activity did not occur) for all three daily shifts. The Administrator and DON (director of nursing) were informed of the findings at a briefing on 03/06/15 at approximately 3:15 p.m. No additional information was submitted for review.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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F 329	Continued From page 16 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documentation review and clinical record reviews, the facility staff failed to ensure the drug regimen was assessed for unnecessary use of antianxiety and antipsychotic medications for two residents (Resident #5, #8) of a 14 resident survey sample. The findings included: 1. For Resident #5, the facility staff failed to implement non-pharmacological interventions prior to or in place of administering an antianxiety medication and a antipsychotic medication which was ordered PRN (as needed). 2. Facility staff did not monitor behaviors for	F 329	**F-329** 1. Resident #5 and #8 behavior monitoring sheets were audited for non pharmacological interventions and proper diagnosis on 3-9-2015. 2. 100% audit of all resident with orders for anti-psychotics was done on 3-9-2015 to identify use of PRN medications. Behavior monitoring sheets were updated to be more individualized on 3-10-2015 . 3. Staff educated on non pharmacological interventions and to use interventions prior to administration of anti-anxiety medications and the policy on behavior monitoring sheets. 4. DON or designee to perform audits of usage of PRN anti anxiety / antipsychotic medications and proper diagnosis weekly and audit the behavior monitoring sheets to ensure non pharmacological interventions were offered prior to medication administration weekly. Audits to be discussed at monthly QAPI for a minimum of 3 months. 5. Date of completion April 17, 2015.	

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F 329	Continued From page 17 Resident #8 for the month of February and did not provide a proper diagnoses for the use of Haldol, an antipsychotic. 1. Resident #5 was admitted to the facility 09/25/2013. Diagnoses included but were not limited to dementia, Anxiety State, asthma, hypertension, Esophageal Reflux and osteoporosis. Review of the resident's clinical record revealed a Quarterly MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 12/09/2014. The resident was coded as having short and long-term memory loss and was assessed as being moderately impaired cognitively as evidenced by making poor decisions regarding safety and requiring cueing and supervision to complete her ADLs (activities of daily living). The resident was further coded as sometimes making self understood and usually understanding others. Under Behavior, the resident was coded as wandering at least four to six days a week but less than daily. Also noted was the resident required extensive assistance of one to two staff members for bed mobility and transferring from different surfaces. The resident did not ambulate and was coded as requiring limited assistance of one staff member while in a wheelchair for locomotion on and off the unit. For dressing, toilet use and personal hygiene, the resident required extensive assistance of one staff member. The resident was totally dependent on one to two staff members for bathing. No functional limitations in range of motion (ability to bend/use joints of the body) on either upper or lower extremities with no impairment coded on either side. Further, the	F 329		

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F 329	Continued From page 18 resident was always incontinent of bladder and bowel. Review of the resident's clinical record revealed a validated physician's order dated 02/26/15: "Ativan (also known as Lorazepam) Solution 2 mg/ml (milligrams per milliliter). Inject 1 ml inject intramuscularly every 2 hours as needed for agitation." Ativan (Lorazepam) is in a class of medications called benzodiazepines, which are used to relieve anxiety. Lorazepam works by slowing activity in the brain to allow for relaxation. (http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html). Review of the MAR (medication administration record) for 02/01/2015-02/28/15 noted the resident received the Ativan once and review of the 03/01/15-03/31/15 MAR documented the resident had received the Ativan three times. Nowhere on the MARs or in the nurses notes was it documented as to what non-pharmacological interventions were used prior to giving the resident the medication. Further review of the resident's clinical record revealed a physician's validated order which noted the following: "03/04/2015 Discontinue Ativan Solution 2 mg/ml injections" and begin "Lorazepam (Ativan) Tablet 1 mg- Give by mouth as needed for anxiety related to Anxiety State." Review of the 03/01/2015-03/31/15, the following was noted: 03/01/15-The Resident received Ativan Solution 2 mg/ml injection at 1:30 p.m. 03/02/15-The Resident received Ativan Solution 2 mg/lm injection at 1:50 p.m. 03/03/15-The resident received Ativan Solution 2	F 329		

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F 329	Continued From page 19 mg/ml injection at 9:00 p.m. 03/04/15-The Resident received Lorazepam (Ativan) tablet 1 mg at 1:17 p.m. 03/05/15-The Resident received Lorazepam (Ativan) tablet 1 mg at 10:23 a.m. The Resident received Lorazepam (Ativan) tablet 1 mg at 9:16 p.m. No documentation could be found on the MAR, in nurses notes or anywhere throughout the resident's clinical record of what, if any non-pharmacological interventions had been used prior to giving the resident the antianxiety medication on a PRN (as needed) basis. An interview was conducted on 03/05/2015 at approximately 2:27 p.m. with the Unit Manager. When asked what non-pharmacological interventions had been used without success prior to giving the resident the antianxiety medication he stated: "I'm not sure. I cannot find the information in the record or on the MARs." The Administrator and DON (director of nursing) were informed of the findings at a briefing on 03/06/15 at approximately 3:15 p.m. No additional information was submitted for review. Resident #8 was originally admitted to the facility on 2/11/15, with diagnoses which included but not limited to dementia, hypertension, stroke, acidosis, altered mental status.	F 329		

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F 329	Continued From page 20 Review of the Resident #8's clinical record revealed the most current MDS (Minimum Data Set- an assessment protocol), an Admission, with an ARD (assessment reference date) of 2/18/15. Resident #8's BIMS score (Brief Interview for Mental Status, an interview to assess mental status) was assessed as a 7 out of a possible 15 indicating severe cognitive impairment. On 3/5/15 at approximately 11:00 a.m., Resident #8's clinical record was reviewed. The clinical record evidenced that Resident #8 was discharged from the hospital on 2/11/15 with discharge medications that included Haldol to be given every night at bedtime and every 8 hours as needed. Physician's orders from the nursing facility read as follows: "Date ordered 2/11/15: Haloperidol Tablet (also called Haldol, an antipsychotic medication) 0.5 mg (milligrams) give 1 tablet by mouth at bedtime related to ALTERED MENTAL STATUS; ALZHEIMER'S DISEASE." "Date ordered 2/11/15: Haloperidol Tablet 0.5 mg give 1 tablet by mouth every 8 hours as needed for agitation related to OTHER AND UNSPECIFIED SPECIAL SYMPTOMS/SYNDROME" On 3/5/15 at approximately 10:55 a.m., the DON (Director of Nursing) stated, "We have not yet located the behavior flowsheets for February." The nurse's notes were reviewed, and no nurses notes pertaining to Resident #8's behaviors could	F 329		

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F 329	Continued From page 21 be found. The clinical record did not evidence an appropriate diagnoses for the use of Haldol. On 3/5/15 at approximately 5:15 p.m., the Administrative team was made aware of the findings. The surveyor informed the Administrative team that there was no appropriate diagnoses for the use of Haldol, and that behaviors were not monitored during the month of February. By the end of the survey the Administrative team could not provide behavior flowsheets for the month of February. The facility provided the policy titled, "Antipsychotic Medication Review", with a creation date of 1/3/14, and a review date of 1/29/14. The policy read as follows: Procedure: To ensure that the Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug. Definition: Antipsychotics are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorder, and is increasingly being used in the management of non-psychotic disorders. Notable and relatively common adverse effects of antipsychotics include extrapyramidal symptoms (which involve motor control) and hyperprolactinaemia (elevated serum prolactin) primarily in typicals and weight gain and	F 329		

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F 329	Continued From page 22 metabolic abnormalities mostly in atypicals. Temporary withdrawal symptoms including insomnia, agitation, psychosis, and motor disorders may occur during dosage reduction of antipsychotics, and can be mistaken for the return of the underlying condition. Procedure Details: On admission for Residents receiving Antipsychotic Medications, review Medical Record for completion of the follow Assessments: Clinical Health Status Depression Scale Cognitive Exam Review the physician's orders for a complete order that includes: Medication name Dose Frequency Appropriate Diagnoses: Schizophrenia Schizoaffective Disorder Psychotic Mood Disorders (Mania and Depression with Pyschotic Features) Acute Psychotic Episodes Brief Reactive Psychotics Schizophreniform Disorder Atypical Psychosis Tourette's Syndrome Huntington's Disease Organic mental syndromes (delirium dementia, amnesic, and other cognitive disorders) with associated psychotic and/or agitated behaviors. Which have been quantitatively and objectively documented, persistent and not caused by preventable reason. And causing the resident to present	F 329		

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F 329	Continued From page 23 danger to self or to others. Or continuously scream, yell, or pace if these specific behaviors causing an impairment in functional capacity. Review that behaviors are being monitored and documented on Care Tracker and/or behavior sheet that is easily accessible to staff. Review to ensure documentation of psychology or psychiatry consults in the Medical Record. These consults should contain documentation which supports the therapeutic benefit for the antipsyhotic medication without serious side effects.	F 329		
F 363 SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation review and staff interviews it was determined the facility failed to ensure pureed foods were prepared by approved recipes to achieve the appropriate consistency for residents who required and had validated physician orders needing a pureed diet. A total of 6 residents required the pureed food consistency diet. The findings included:	F 363		

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F 363	Continued From page 24 An observation was made on 03/05/15 at approximately 11:45 a.m., of the staff plating food from the steam table. The Dietary Manager was in attendance. At the beginning of the plating of the food the pureed baked fish appeared to be of the correct consistency as the cook was able to cut the pan of prepared pureed fish, which held its consistency onto a serving plate. The cheesy fettuccine appeared as very formed mashed potatoes and were scooped onto the serving plate and it held its consistency. The seasoned spinach as it was scooped onto the serving plate did not hold its consistency as it was placed onto the plate. When the plating of the food was completed at approximately 12:15 p.m., an interview was conducted with Other #3, the cook, without the Dietary Manager being present. When asked about how the pureed foods were prepared she stated: "We put it into the food processor and when it is the consistency of baby food the preparation is completed." When asked if recipes were used to ensure the consistency is correct she stated: "I was trained to use the food processor and to add enhancer-thickener-into the food until it was the consistency of baby food." When the cook was asked what the consistency of baby food was she was not able to specify the thickness or thinness of the product. When asked if she had used any recipes for pureed food regarding the type of additive or additional liquid was used to ensure the consistency she state: "I only use the recipes to cook the food, not to prepare it." An interview was conducted on 03/05/15 at approximately 2:45 p.m., with the Dietary	F 363	**F - 363** 1. All residents that could have been effected were given alternate tray's with the food prepared per recipe and the correct consistency. 2. Dietary manger to observe meal preparation to ensure staff are following recipes and policy . 3. A designated book will be implemented for recipes for all pureed diets. and kept in the kitchen . DSM/Designee to observe meal prep daily and sign off audit sheet to ensure compliance. 4. Dietary manager or designee will audit the recipe book daily to ensure recipes are being followed audits will be discussed at QAPI for minimum of 3 months 5. Date of completion April 17 , 2015.	

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F 363	Continued From page 25 Manager. She stated: "We have recipes to prepare the pureed foods correctly and I don't know why they have not been used." The Dietary Manager then submitted the three recipes for preparation that had been on the noon time menu. The menus for the three pureed items were reviewed and it was noted that for each individual food item the recipes stated how much measured liquid consisting of milk 2%, water with chicken base, and vegetable liquid was to be used. The recipes also included how much measured enhancer natural puree shaper and instant food thickener were to be used after the foods had been processed in the food processor. No where on the recipes did it state: "Baby food consistency." The Administrator and DON (director of nursing) were informed of the findings at a briefing on 03/06/15 at approximately 3:15 p.m.. No additional information was submitted for review.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 371		

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F 371	Continued From page 26 facility staff failed to prepare and serve food under sanitary conditions as evidenced by two male staff members with uncovered facial hair observed in the kitchen during the food plating process from the steam table and also observed circulating throughout the kitchen. The findings included: Observations were made of the kitchen and staff on 03/05/15 at approximately 11:15 a.m., and the Dietary Manager was in attendance. During the observation of the cook taking the temperatures of the food on the steam table, one male kitchen tech was observed to be standing at the steam table without having his chin whiskers covered or contained. The lack of the male kitchen tech having his facial hair covered was brought to the attention of the Dietary Manger. She stated: "I told them they had to have their beards covered." She then directed the male kitchen tech to leave the steam table area to obtain facial covering before returning to actively participate with the plating of the food from the steam table. A observation was made during the same period of another male kitchen tech circulating throughout the kitchen without having his facial hair contained. When this was brought to the Dietary Manager's attention she stated: "I didn't know that they had to have their beards covered unless they were actually within the area where food was prepared or served. I will direct him to cover his beard." An interview was conducted on 03/06/15 at	F 371	**F- 371** 1. Dietary staff were instructed to wear facial covering immediately. 2. Dietary manager to be present at meals to ensure male staff have facial hair covering on when in kitchen and track compliance via spreadsheet and sign of on the sheet daily. 3. Staff in serviced on the policy and requirement for wearing hair covering when preparing food. 4. Dietary manger or designee will check daily to ensure that staff are wearing the proper hair coverings per policy and Audits to be discussed at QAPI for a minimum of 3 months. 5. Date of completion April 17, 2015.	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	495264	A. BUILDING _____ B. WING _____	03/06/2015

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 27 approximately 2:45 p.m., with the Dietary Manager. She stated: "I had told the men that they had to wear beard covers for any facial hair when they are in the kitchen. The Administrator and DON (director of nursing) were informed of the findings at a briefing on 03/06/15 at approximately 3:15 p.m. No additional information was submitted for review.	F 371		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review facility staff failed to obtain ordered labs for 1 of 14 residents, (Resident #8). The findings included: Resident #8 was originally admitted to the facility on 2/11/15, with diagnoses which included but not limited to dementia, hypertension, stroke, acidosis, altered mental status. Review of the Resident #8's clinical record revealed the most current MDS (Minimum Data Set- an assessment protocol), an Admission, with an ARD (assessment reference date) of 2/18/15. Resident #8's BIMS score (Brief Interview for Mental Status, an interview to assess mental status) was assesses as a 7 out of a possible 15	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 502	Continued From page 28 indicating severe cognitive impairment. On 3/5/15 at approximately 11:00 a.m., Resident #8's clinical record was reviewed. The physician's orders read as follows: "2/12/15-CBC (Complete Blood Count), FreeT4/TSH (thyroid stimulating hormone), lipid panel, Vit. (vitamn) D 25, PSA (prostate screening), one time only until 2/14/15" The results could not be found in the clinical record. On 3/5/15 at approximately 1:00 p.m. the surveyor asked the DON (Director of Nursing), "Can you find me the results for these labs." The DON indicated that she would look for it. On 3/6/15 at approximately 11:00 a.m., the DON stated, "The labs were not drawn, I notified the physician, and they were done this morning." On 3/6/15 at 5:15 p.m. the administrative team was made aware of the findings. The administrative team provided the policy titled, 'Lab Processing/Tracking Guideline,' with a revision date of 1/6/15. The policy read as follows: Guideline Statement: To ensure that Diagnostic tests are processed, ordered, obtained, performed, and results received timely. Test results are communicated to the physician in a timely manner with documentation present in the medical record. Facility Diagnostic Testing System Review: 1. As a part of the Clinical Start-Up process, the DNS (Director of Nursing Services) or designee will identify any new diagnostic orders received by the following methods: A review of the 24-hour report forms on each	F 502	**F- 502** 1. Resident # 8 labs were obtained on 3-6-2015. 2. 100 % audit of lab orders in the last 30 days was done on 3-9-2015. 3. DON or designee will perform a diagnostic review by reviewing the 24 hour report , review PCC and use AMALGA to ensure labs are obtained as ordered. Audit to be done daily . 4. DON or designee will sign off on the reports and track the results and results of tracking will be discussed at QAPI for at least 3 months. 5. Date of completion April 17, 2015.	

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F 502	Continued From page 29 nursing unit A review of the new orders generated through the PCC (point care click system) Communication with the staff while making start-up rounds on the nursing units. 2. The DNS or designee will review the Diagnostic Tracking Form or Amalga module to ensure that the tracking process was initiated. This review is to monitor that any new orders were processed, results were obtained, physician notification was conducted and that timely physician response was received. Any identified issues are to addressed by the DNS. 3. Refer to the Diagnostic Lab Ordering/Tracking Flow Diagram. Monitoring/Compliance Labs are scheduled and drawn as per physician's orders Evidence that the Diagnostic/Lab tracking tool is being utilized effectively Evidence exists the lab processes is monitored daily during clinical start up.	F 502		